No. 90-97

In The

Supreme Court of the United States

October Term, 1990

AMERICAN HOSPITAL ASSOCIATION,

Petitioner,

v.

NATIONAL LABOR RELATIONS BOARD, ET AL.,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

BRIEF OF THE MISSOURI HOSPITAL ASSOCIATION AND ILLINOIS HOSPITAL ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page

TABLE OF AUTHORITIES – Continued

Page

STATEMENT OF INTEREST OF THE MISSOURI HOSPITAL ASSOCIATION AND THE ILLINOIS HOSPITAL ASSOCIATION AS *AMICI CURIAE*

This brief is submitted on behalf of the Missouri Hospital Association ("MHA") and Illinois Hospital Association ("IHA") in support of petitioner, the American Hospital Association ("AHA"). The Missouri Hospital Association was an active participant in the hearings before the National Labor Relations Board ("Board") concerning the promulgation of the rule governing collective bargaining units in the health care industry. The MHA offered testimony through two of its leading health care executives and submitted written comments to the Board. The MHA also participated as an *amicus curiae* before the court of appeals for the Seventh Circuit.

The MHA has 139 acute-care hospital members, representing 98 percent of the acute-care hospitals in the state of Missouri. The IHA has 211 acute-care hospital members, representing virtually all of the acute-care hospitals located in the state of Illinois. The membership of both associations ranges from large tertiary care referral centers in major metropolitan areas to very small primary care hospitals in rural areas. The diversity of the MHA and the IHA membership and the general diversity of the health care industry in Missouri and Illinois are of particular relevance to the issues in the AHA's petition. The MHA's and IHA's member hospitals are health care industry employers subject to the rule promulgated by the Board. As such they and the patients they serve have a significant and direct interest in the granting of the AHA's petition.

The MHA and IHA agree with the AHA's legal position that the rule promulgated by the Board violates both the mandate of Section 9(b) of the National Labor Relations Act (the "Labor Act") that bargaining unit determinations be made "in each case," and the Congressional admonition against undue proliferation of bargaining units in the health care industry, contained in the legislative history of the 1974 Health Care Amendments to the Labor Act. The MHA and IHA rely upon the arguments made by the AHA in support of those positions. The MHA and IHA, as *amici*, will not restate those arguments but will focus on Missouri's and Illinois' experience and demonstrate 1) the necessity of individualized bargaining unit determinations in light of the diverse and rapidly changing health care industry, 2) the proliferation of bargaining units in acute-care hospitals that necessarily will follow application of the rule, and 3) the potential adverse impact upon health care of hospital-by-hospital challenges to the validity of the bargaining unit rule.

The Board has concluded that there are no differences among acute-care hospitals which are relevant to bargaining unit determinations. The MHA and IHA find this conclusion to be incredible and irrational in light of the wide range of hospital organizations and their relationships with their employees. In this regard, Missouri and Illinois are microcosms of the country, with major metropolitan hospitals at one end of the spectrum and small rural hospitals at the other. The MHA and IHA, as representatives of the vast majority of Missouri and Illinois hospitals, believe they have information relevant to this Court's consideration of the AHA's petition for a writ

of certiorari to the United States Court of Appeals for the Seventh Circuit.

REASONS FOR GRANTING THE PETITION

I. THE DIVERSE AND RAPIDLY CHANGING HEALTH CARE INDUSTRY REQUIRES INDIVIDUALIZED BARGAINING UNIT DETERMINATIONS.

Section 9(b) of the Labor Act provides, in part, that:

> The Board shall decide *in each case* whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this subchapter, the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof . . . .

28 U.S.C. § 159(b) (emphasis added). The mandate of this language is clear: the Board must determine the appropriateness of a bargaining unit on an individual basis, considering the particular facts at hand. The Board, by promulgating an essentially irrebuttable rule for determining bargaining units in acute-care hospitals, has shirked its statutory responsibility to conduct this factual review and make an individual decision.

The Board's Final Rule provides that "[e]xcept in extraordinary circumstances . . . the following shall be appropriate units, and the only appropriate units . . . " and lists eight separate bargaining units. Final Rule, 54 Fed. Reg. 16347-16348 (1989). The only specific example of an "extraordinary circumstance" given by the Board is "a unit of five or fewer employees." *Id.* at 16348. In the Supplementary Information accompanying the Final Rule the Board reaffirmed the narrow scope of the "extraordinary circumstances exception" as previously set forth in its Second Notice of Proposed Rulemaking ("NPR II"). *Id.* at

16345. In NPR II the Board, in addressing variations between acute-care hospitals, stated that

> The Board has considered fully and at length all evidence presented and arguments submitted at the rulemaking hearings and during the comment period. None of the referred-to variations between acute care hospitals, some of which are enumerated below, are matters which would qualify for litigation under the special circumstances exception; rather, they are merely minor differences, inherent in the industry due to the multiformity of individual constituent institutions.

NPR II, 53 Fed. Reg. 33932.[1] This sweeping dismissal of any further consideration of the diversity of acute-care

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[1] The Board provided the following enumeration of "minor differences" in acute-care hospitals:

> Among the variations in acute care hospitals illustrated at the hearings and considered by the Board are arguments relating to: (1) Diversity of the industry, such as the sizes of various institutions, the variety of services offered by individual institutions, including the range of outpatient services provided, and differing staffing patterns among facilities (as, for example, a particular facility employing a larger or smaller number of RNs than generally employed by similarly situated hospitals); (2) increased functional integration of, and a higher degree of work contacts between employees as a result of the advent of the multi-competent worker, increased use of "team" care, and cross-training of employees; (3) the impact of nationwide hospital "chains"; (4) recent changes within traditional employee groupings and professions, e.g., the increase in specialization among RNs; (5) the effects of various governmental and private cost-containment measures; and (6) single institutions occupying more than one contiguous building.

NPR II, 53 Fed. Reg. at 33932.

hospitals as "merely minor differences" is a flagrant violation of the "in each case" requirement of Section 9(b) and flies in the face of any realistic analysis of the health care industry. The court of appeals decision upholding the validity of the bargaining unit rule also ignores the importance of the differences among acute-care hospitals.

A. The Board's Rule Is Arbitrary And Capricious In That It Ignores The Diversity Of Acute-Care Hospitals.

The variations in the hospital industry in Missouri, as elsewhere, hardly can be considered "merely minor differences" as the Board concluded. The MHA submits that such variations are significant and are relevant to the determination of bargaining units. The Board's rule is arbitrary and capricious in that it ignores any and all differences among acute-care hospitals. In support of its position, the MHA offers the following information concerning the diversity of the hospital industry in Missouri.

There are 142 acute-care hospitals in Missouri, 139 of which are members of the MHA. Of the member hospitals, seventy-two are rural and sixty-seven are urban.[2] The largest member hospital has 1,208 licensed beds and the smallest has eighteen licensed beds. The member hospital with the largest staff employs the equivalent of 5,262 full-time employees; the smallest employs twenty-eight. The number of full-time registered nurses employed by member hospitals ranges from 1,201 to three.

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[2] The terms "rural" and "urban" as used for purposes of MHA statistics are as defined in the Medicare Regulations at 42 C.F.R. § 412.62(f).

Forty-five member hospitals have beds designated as "swing beds," i.e., beds which may be designated from time to time either as skilled nursing care beds or acute-care beds at the discretion of the institution. Forty-five member hospitals have long-term care or nursing home units which are operated either in separate locations, in separate buildings on the hospital campuses or on separate floors within the hospitals' main buildings.

The services provided by the MHA member hospitals, and their related organizations, also vary widely. Some member hospitals provide basic inpatient and outpatient general care services while others operate, often through subsidiary corporations, activities such as home health agencies, inpatient and outpatient psychiatric units, multi-location outpatient clinics, outpatient surgical facilities and rehabilitation facilities.

Each of these types of hospitals and, indeed, each of these hospitals, has a different employee mix and a different administrative structure. They have different ratios of one type of employee to another and of all employees to patients as well as different levels of integration among various employee groups. It should not require evidence or hearings to conclude that the employees of a twenty bed hospital in rural Denton County, Missouri are organized in a different fashion than the employees of a 1,200 bed hospital in metropolitan St. Louis, Missouri. The patient acuity levels are substantially higher at the latter institution than at the former. Generally speaking, the higher the acuity level of the particular institution, the more skills that must be brought to bear upon each patient's needs at the same time. Thus, the higher the acuity, the greater the functional integration of the many levels of employees needed to care for a single patient.

On the other hand, the large urban institution, with thousands of employees, is more likely to be able to hire fairly narrow specialists and concentrate their responsibilities within their primary area of expertise while the rural hospital, with far fewer employees, must ask each employee to wear more hats and fill more roles. While a well-baby clinic in a rural hospital might have relatively few employees and disciplines applied to each patient, an intensive care unit in a tertiary referral center would require a large number of multi-disciplined employees working closely together to administer care.

An example of the high level of integration of the various classifications of health care employees is found in the fact that at one acute-care hospital in Kansas City, with only 240 staffed beds, registered nurses work in fifteen departments and occupations in addition to being staff nurses or operating room nurses.[3] These registered nurses work in utilization review, risk management, quality assessment, social services, education, a preferred provider organization, medical records, admitting, administration, outpatient clinics, radiation therapy, central services, DRG coordination and review, employee health, infection control and the wellness clinic. At that institution, approximately 10 percent of the nurses are not in patient-care areas and only 70 percent are in traditional acute patient-care settings.[4] Nonetheless, the Board

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[3] See, Testimony of Dan H. Anderson, Supplemental Appendix of Plaintiff-Appellee submitted to the court of appeals for the Seventh Circuit ("S.A.") at 482.

[4] See, November 6, 1987 letter to counsel for American Federation of Labor and Congress of Industrial Organizations, submitted to the Board as part of the administrative record.

would require all of these registered nurses from the many different departments, who have virtually nothing in common with each other except their state licensure but a great deal in common with other employees with whom they work on a daily basis, to be lumped into a single bargaining unit separate from all other employees. Such a result confounds reason and arbitrarily ignores the fact that *"in each case"* and particularly in *this* case a different result is required.

The Board's refusal to recognize the significance and relevance of the differences among acute-care hospitals is particularly illogical and inconsistent in light of its reasons for exempting nursing homes from the impact of the bargaining unit rule. In the Second Notice of Proposed Rulemaking the Board concluded that there are "significant differences between the various types of nursing homes which affect staffing patterns and duties." NPR II, Fed. Reg. at 33928. As evidence in support of this conclusion the Board noted that "[t]o a larger extent than acute care hospitals, nursing homes vary both in size and type of service rendered." *Id.* at 33927. This assertion simply is incorrect.

In support of its assertion the Board cited evidence that nursing home facilities range in size from ten to 500 patients. *Id.* As stated above, acute-care hospitals in Missouri vary to an even greater degree, from eighteen to 1,208 licensed beds. The Board also cited evidence concerning the differing levels of care among the three basic types of nursing home facilities: skilled nursing, intermediate care and residential care. *Id.* There are hospitals in Missouri, however, where the level of care varies to an even greater degree within one institution. One hospital in Kansas City provides care ranging from acute intensive

and emergency care to long term residential care, with several levels and types of care between the extremes.

If the Board's findings with respect to the nursing home industry are correct, its irrebuttable rule for the substantially more highly diverse and more rapidly changing hospital industry must be incorrect. The Board's rationale for excluding nursing homes from the coverage of the rule requires precisely the same finding when applied to acute-care hospitals.

The Board's reasoning concerning the applicability of the rule to facilities providing care to psychiatric and rehabilitation patients also is inconsistent. The rule does not apply to facilities that are primarily psychiatric or rehabilitation hospitals, but *does* apply to psychiatric or rehabilitation units within facilities that fit within the rule's definition of an acute-care hospital. Under this scheme, the employees working on one of the floors of a 100 bed psychiatric unit at a large metropolitan hospital would be subject to the rule's mandatory bargaining unit determinations but the employees working at a 100 bed psychiatric hospital would not.[5] There is absolutely no rational basis on which to make such a distinction. The reasons offered by the Board in support of its decision to exclude psychiatric hospitals from the rule apply with equal force to psychiatric units within acute-care hospitals.[6]

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[5] Both situations are found among MHA's members.

[6] Among the reasons offered by the Board were: "that unlike other acute care hospitals, psychiatric hospitals do not provide care for the physically ill," that "many professionals participate hands-on with patients," that "RNs' work is closely integrated with the work of clinical psychologists, counselors,

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B. The Board's Rule Is Arbitrary And Capricious, Especially As It Applies To Small And Rural Hospitals With Widely Divergent Operations.

Fixed NLRB rules establishing pre-ordained hospital bargaining units are arbitrary and capricious.[7] What is even more alarming is that the Board would seek to apply its rule to rural hospitals, carving out eight separate units for these small community institutions. This will have a disastrous effect on the delivery of health care services.

The Board is wrong. All hospitals are not alike. The differences among hospitals are substantial with wide ranges in size, purpose, scope, function, operations and staff. It is clear that the Board ignored the record which is replete with evidence that hospitals are quite distinct from one another. It is disingenuous for the Board to take a contrary position when, since the inception of the health care amendments to the Labor Act, the Board itself has recognized these distinctions.[8]

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social workers, and various types of therapists in a treatment plan as designated by doctors and program coordinators" and "that there are more paraprofessionals (mental health workers)." NPR II, Fed. Reg. at 33930.

[7] See Brief of American Hospital Association, Petitioner pp. 26-28.

[8] In *Otis Hospital*, 219 NLRB 55 (1975) the Board stated: " . . . the conclusion we reach is acknowledgement that not all health care institutions may be exactly alike. That is, we feel, the first lesson learned from the recent debates [over the health care amendments]. Between categories of employees similarly titled there may be significant differences, not only in wages, hours, supervision, and the like, but more importantly in functions, responsibilities, procedures, and even expertise. Practice

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Moreover, the Board's rule simply will not foster stability and harmonious labor relations during these times of immense and turbulent changes in the health care industry.[9] What is occurring now among Illinois rural hospitals is instructive of how our country's acute health care system is revolutionizing. Hospitals are closing. From 1983 to 1990, 23 Illinois hospitals closed: 39% of these were small and rural hospitals. Eight small rural hospitals closed in two years alone.[10] Nineteen counties in rural Illinois were left with no community hospital facility to provide health care.

Both patient admissions and inpatient days have declined significantly for rural facilities, a drop of approximately 27% from 1983 to 1988. The decrease of inpatient services has been offset by an expanding demand for outpatient services, which has increased 29%

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or standards may differ from one locale to another, not only with respect to collective-bargaining patterns but also with respect to health care delivery itself. When parties contest the emphasis to be given to such characteristics, we are, of necessity, the arbiter." See also, *St. Francis Hospital*, 271 NLRB 948, 953 n. 39 (1984) where the Board found "the diverse nature of today's healthcare industry precludes any generalization as to the appropriateness of any particular bargaining unit."

[9] The extent to which the Board's rule is arbitrary is demonstrated by its summary dismissal of the revolutionary changes impacting the delivery of healthcare. As noted *supra* p. 4, note 1, in NPR II, 53 Fed. Reg. at 33932, the Board cavalierly dismissed as "merely minor differences" the revolutionary changes and diversity in hospital operations.

[10] The statistical information provided by Illinois healthcare facilities and cited herein appears in *Trends, Small, Rural and Public Hospitals in Illinois: A Six Year Perspective, 1983-1988*, a 1990 publication of the Illinois Hospital Association.

over the same period. Not surprisingly, the statewide hospital bed occupancy rate dropped from 70% in 1984 to less than 63% in 1988. Rural hospital occupancy is dramatically lower. Rural hospitals under 100 beds had occupancy rates averaging between 42.7% and 47.3% in 1988. In 1985, the average number of patients hospitalized on any given day was approximately the same as those treated on an outpatient basis. Yet by 1988, the number of outpatients exceeded the number of inpatients by an average of nearly 2,800 each day for small rural hospitals. This ratio continues to grow and affects the nature and situs of operations, services and the staffing by occupational group.[11]

> By the year 2000 only 30% of healthcare will be delivered as inpatient care in hospitals; 45% will be ambulatory care; and 25% will be home care . . . . Also, there will not be full fledged hospitals anymore. . . . Instead there will be super 'tertiary advanced technology centers', community care centers, and ambulatory centers or *hospitals without beds.*[12] (emphasis added)

The revolution will bring about dramatic changes in staffing, particularly at small and rural hospitals. From 1984 to 1988 Illinois rural hospitals saw a 7% reduction in full-time equivalent personnel. Some of the occupational

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[11] See "Outpatient Care: A Nationwide Revolution," *Hospitals Magazine* 28 (August 5, 1990). The Board's rule completely fails to acknowledge, much less deal with, this health care revolution.

[12] Address by Mark Howard, chief executive officer Intermountain Hospitals, Salt Lake City, Utah, to the 26th annual meeting and conference of the American Society for Healthcare Human Resources Administrators, July 18, 1990, Orlando, Florida. 4 *Labor Relations Week*, 728 (August 1, 1990).

groupings carved out by the Board's rule have experienced even larger reductions. For instance, employment of licensed practical nurses, the single largest occupational category in a technical employee bargaining unit, has declined by more than 27% in the past four years. Yet the Board would force technical units to be recognized wherever sought, regardless of changing circumstances.

Hospitals of all sizes and types have been plagued by financial problems which the Board chooses to ignore. The annual rate of increase in expenses has averaged between 3% and 5% each year. The amount of uncompensated charity care for rural hospitals has continued to grow. Recently, rural hospitals under 100 beds have reported large annual deficits on hospital operations averaging 2.7% to 4.6%. Expenses will grow if the Board's rule calling for multiple bargaining units is implemented.[13]

One Illinois hospital exemplifies how untenable the Board's fixed rule would be.[14] In 1976, St. Joseph's

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[13] "In the hearing before the NLRB on rulemaking, there was substantial evidence presented as to the problems caused and costs incurred by multiple bargaining units in health care institutions. Direct costs associated with one round of bargaining for six units were over $250,000. It was projected that negotiating one round of eight separate contracts would result in costs approaching $360,000. It is a wonder therefore, that the NLRB has chosen to saddle this industry with costly, repetitive, and largely duplicative negotiations as a result of its proposed rules.", Stickler, "Union Organizing Will Be Divisive and Costly," *Hospitals Magazine*, 68 (July 5, 1990).

[14] One must look to this sort of example to see the impact of rulemaking because there is no significant history of collective bargaining among employees in 220 Illinois hospitals.

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Hospital, Highland, Illinois, was a 144-bed facility providing a full range of acute-care services. It had a total work force of 370 employees. Today St. Joseph's operates and staffs a single facility which houses a 40 bed acute-care hospital and a 30 bed skilled nursing facility. Many of the services provided in 1976 have been scaled down, contracted out or no longer are provided. In 1990, the average daily inpatient census is only 19 acute-care hospital patients, and 28 skilled nursing care patients.[15] Moreover, the staff has been reduced from 370 hospital employees to 208 hospital and skilled nursing full-time equivalent personnel for the combined operation.

The hospital, which had a surplus from hospital operations in the 1970's, has had a deficit from operations in 10 of the past 11 years. Without outpatient revenue, the hospital would cease to be financially viable.

Assuming, *arguendo*, that the Seventh Circuit decision is denied review, the Board's rule would potentially result in six separate units, with six separate contracts to

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Thus, more than 92% of all Illinois hospital workers are non-union. Fewer than 2% of all registered nurses are members of a labor organization. Moreover, since the 1974 Health Care Amendments to the Taft-Hartley Act, RNs have been organized in only 3 units that include all other professional employees. See, *Testimony On Appropriate Bargaining Units In The Health Care Industry Before the NLRB*, September 1, 1987, as attachment 10 to the American Hospital Association comments on proposed rule "Collective Bargaining Units In The Health Care Industry" (29 CFR Part. 103), December 17, 1987.

[15] The average length of stay of acute-care hospital patients is approximately 7.0 days. The average length of stay of skilled nursing patients is 47 days.

be negotiated and administered at St. Joseph's Hospital.[16] The costs of negotiating and administering six different contracts would threaten the very existence of this small rural hospital. Hundreds of small, rural hospitals located throughout the country could suffer similar experiences and potentially disastrous results from the Board's bargaining unit rule.

Missouri and Illinois truly are microcosms of the health care industry. The members of the MHA and IHA do not fit some artificial hospital profile which fills the Board's need to categorize hospitals and their employees in neat pigeonholes and thereby avoid its statutory obligation to make individual findings in each case. They are real hospitals serving real people in the rural areas, small towns, suburbs and urban centers of incredibly diverse states. They, their employees and their organizational structures reflect that diversity and it is arbitrary and capricious for the Board to ignore reality in favor of some artificial norm which exists only in the mind of the Board.

II. THE RULE WILL RESULT IN A PROLIFERATION OF BARGAINING UNITS IN ACUTE-CARE HOSPITALS.

In 1974, when Congress amended the Labor Act to include not-for-profit hospitals, it included in its Committee reports the following admonition:

> Due consideration should be given by the Board to preventing proliferation of bargaining

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[16] There are no employed physicians nor security guards who would constitute the seventh and eighth units. The size of the units would range from six business office clericals and eight maintenance and grounds employees at the low end to a unit of forty-five service employees in the largest unit.

> units in the health care industry. In this connection, the Committee notes with approval the recent Board decisions in *Four Seasons Nursing Center*, 208 NLRB No. 50, 85 LRRM 1093 (1974), and *Woodland Park Hospital*, 205 NLRB No. 144, 84 LRRM 1075 (1973), as well as the trend toward broader units enunciated in *Extendicare of West Virginia*, 203 NLRB No. 170, 83 LRRM 1242 (1973).
>
> By our reference to *Extendicare*, we do not necessarily approve all of the holdings of that decision.

S. Rep. No. 93-766, 93d Cong., 2d Sess. 5 (1974); H.R. Rep. No. 93-1051, 93d Cong., 2d Sess. 6-7 (1974).

As the District Court in this case recognized "[t]he stakes are higher when the Board makes bargaining unit determinations in the health care field, fragmentation of the workforce is more likely and of greater concern when patient care is at issue." Petitioner's Appendix ("Pet. App.") at 36a. The District Court concluded that, in promulgating a rule which "designates an absolute number of appropriate units and mandates a particular division of the workforce," the Board was not responsive to the express concerns of Congress. Pet. App. at 41a-42a. The District Court based its conclusion, in part, on the fact that the rule requires the "*automatic* fragmentation of the workforce into eight units, without regards to the nature and extent of the health services rendered or the dynamics of a particular health care institution." Pet. App. at 37a (emphasis in original).

The MHA believes that this conclusion also is supported by the history of organizational activity that has occurred in Missouri. Labor organizations in this state have not hesitated to seek to represent broader units of employees than those that will be mandated by the rule.

For example, in a 1986 election at Spelman Memorial Hospital (Case No. 17-RC-9796), the International Brotherhood of Teamsters sought two units, one of professional employees and one of nonprofessional employees. In an earlier election at the same institution in 1980, Local 96 of the Service Employees International Union (Case No. 17-RC-8917) sought the same two units.

In another 1980 case, the Board conducted an election in two units sought by Local 50 of the Service Employees International Union, one of all ambulance department employees and the other of all other employees employed at Wright Memorial Hospital in Trenton, Missouri. In that case the finding of a separate unit of ambulance drivers and emergency medical technicians was a result of a unique organizational structure that made such a unit appropriate. In the same case the Board concluded, contrary to what might normally be found, that all registered nurses in the hospital actually functioned as Section 2(11) supervisors and, therefore, were not employees for purposes of organization under the Labor Act. *Wright Memorial Hosp.*, 255 NLRB 1319 (1981). After taking extensive testimony in that case, the Board itself demonstrated why presumptions and rules are not appropriate in this industry. If the Board, in that instance, had chosen to assume that nurses are nurses and hospitals are hospitals, it never would have taken cognizance of the unique organizational structure of the emergency services and the unique responsibilities of the registered nurses at Wright Memorial Hospital. Such a failure would have altered substantially the outcome of the case.

III. THE VALIDITY OF THE RULE IS OF GREAT SIGNIFICANCE TO HOSPITALS IN MISSOURI, ILLINOIS AND ACROSS THE COUNTRY.

The bargaining unit rule promulgated by the Board and upheld by the court of appeals for the Seventh Circuit applies to the vast majority of acute-care hospitals in Missouri, Illinois and across the nation.[17] The validity of the rule is of importance not only to those hospitals within the jurisdiction of the Seventh Circuit, but to the health care industry nationwide. The MHA and IHA believe that this issue, involving the interpretation of a federal statute, is of sufficient national importance to warrant consideration by this Court.

Within the Seventh Circuit, this Court's consideration of the validity of the bargaining unit rule is essential to remedy the errors committed by the Board and the Court of Appeals.

Outside the Seventh Circuit, the validity of the bargaining unit rule will be at issue in every acute-care hospital bargaining unit determination made by the Board. The opportunity for hospitals to raise the issue of the validity of the rule in a specific case, however, will not occur before a great deal of time and resources have been expended by the Board, hospital, union and employees involved. Although a hospital may object to the Board's application of the bargaining unit rule when a unit is certified, the hospital does not have an opportunity to challenge the validity of the rule or the bargaining unit in court until after a union has been elected. If the hospital believes the bargaining unit mandated by the

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[17] Governmental hospitals are the only acute-care hospitals that are excluded from the Labor Act and the rule.

rule is inappropriate it may refuse to bargain with that unit and defend its position in its own Court of Appeals. Only then may the hospital challenge the validity of the rule which served as the basis for the union election. These hospital-by-hospital challenges likely will result in a conflict among the courts of appeals which this Court ultimately will be asked to resolve.

In addition, the potential exists for a multiplicity of lawsuits similar to the one filed by the AHA seeking injunctive and declaratory relief from the application of the Board's rule. Absent review by this Court, hospitals and hospital associations outside the Seventh Circuit may choose to challenge the validity of the rule as promulgated rather than wait for a specific application of the rule by the Board. These challenges also could result in a conflict among the circuits and further petitions for review by this Court.

Hospital-by-hospital and state-by-state challenges to the validity of the bargaining unit rule will place an extreme burden on the already overburdened hospital industry. Hospitals nationwide should not be forced to choose between acquiescing to an invalid rule because it is too costly to challenge and expending scarce resources on litigation. This Court can eliminate this Hobson's choice by granting the petition for certiorari and resolving this issue.

CONCLUSION

For the forgoing reasons, and those stated in the brief of petitioner, the MHA and IHA respectfully request that the American Hospital Association's petition for a writ of certiorari be granted.

Respectfully submitted,

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